Title: Adult Dental Services (Statewide and Self-Determination Waiver only)

Service Definition (Scope):

Adult Dental Services shall mean medically necessary:

a. Dental procedures (e.g., fillings, root canals, extractions, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current "TennCare Maximum Reimbursement Rate Schedule for Dental Services" that is used specifically for HCBS waiver-dental services; and

b. Intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications.

Orthodontic services, routine dental exams and cleanings, and preventive services are excluded from coverage.

Adult Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Dental residents in training may provide Adult Dental Services if they work under the direct supervision of a licensed dentist who is physically present when such services are being provided and if the licensed dentist materially participates in the provision of the Adult Dental Services.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Adult Dental Services shall be limited to a maximum of $5,000 per waiver participant per waiver program year, and a maximum of $7,500 per waiver participant across three (3) consecutive waiver program years.

Title: Behavior Services

Service Definition (Scope):

Behavior Services shall mean:

a. Services to assess and ameliorate waiver participant behavior that jeopardizes the health and safety of the waiver participant, that endangers others, or that prevents the waiver participant from being able to successfully participate in community activities; and

b. Development, monitoring, and revision of behavior intervention strategies, including development of a Behavior Support Plan and staff instructions for caregivers who are responsible for implementation of prevention and intervention strategies; and

c. The initial training of caregivers on the appropriate implementation of behavior intervention strategies, including the Behavior Support Plan (BSP) and staff instructions.

Therapeutic goals and objectives shall be required for waiver participants receiving Behavior Services.

Behavior Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Speech, Language, and Hearing Services unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently.

Behavior Services shall be provided face to face with the waiver participant except for:

a. Waiver participant-specific training of staff; and

b. Behavior assessment and plan development; and

c. Presentation of waiver participant behavior information at human rights committee meetings, behavior support committee meetings, and waiver participant planning meetings. Reimbursement for presentation of waiver participant behavior information at meetings shall be limited to a maximum of 5 hours per waiver participant per year per provider.

Behavior assessments, behavior plan development, and presentations at meetings shall not be performed by Behavior Specialists. Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment (32 qtr. hour units per year) with a maximum of 2 assessments per year.

Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 days following its approval for use shall be limited to a maximum of 6 hours (24 qtr. hour units per year).

Reimbursement shall not be made for travel time to meetings and for telephone consultations, but may be made for consultations with the waiver participant's treating physician or psychiatrist during an office visit when the waiver participant is present.

Reimbursement for presentation of person behavior information at human rights committee meetings, behavior support committee meetings, and person planning meetings shall be limited to 5 hours per provider (20 qtr. hour units per year).

Behavior Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program, including psychological evaluations and psychiatric diagnostic interview examinations.

Behavior Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Applicable limits, if any, on the amount, frequency, or duration of this service:

- 8 hours per assessment for completion of the behavior assessment; 2 assessments per year.
- 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per year.
- 5 hours for presentations at meetings per year.

Title: Behavior Respite

Service Definition (Scope):

Behavioral Respite Services shall mean short-term behavior-oriented services for a waiver participant who is experiencing a behavioral crisis that requires removal from the current residential setting in order to resolve the behavioral crisis.

Behavioral Respite Services shall be provided in a setting staffed by individuals who have received training in the management of behavioral issues. Direct support staff must have received training in the prevention and management of crisis behavior. Behavioral Respite Services may be provided in a Medicaid-certified ICF/IID, in a licensed respite care facility, or in a home operated by a licensed residential provider. Behavioral Respite Services shall not be provided in a home where a waiver participant lives with family members unless such family members are also waiver participants receiving Behavioral Respite Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

The Behavioral Respite Services provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the waiver participant is not at school; including behavioral supervision and intervention for aggressive or inappropriate behavior that jeopardizes the health and safety of the waiver participant or others. The Behavioral Respite Services provider shall oversee the waiver participant's health care needs. Behavioral Respite Services providers shall be responsible for the cost of any Day Services needed while the waiver participant is receiving Behavioral Respite Services.

Reimbursement for Behavioral Respite Services shall not include payment for Behavioral Respite Services provided by the spouse of a waiver participant. The Behavioral Respite Services provider and provider staff shall not be the parent or custodial grandparent of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Behavioral Respite Services provided by such individuals.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Behavioral Respite Services and shall be included in the reimbursement rate for such.

A waiver participant who is receiving Behavioral Respite Services shall not be eligible to receive Personal Assistance, Respite, or Day Services (which would duplicate services that are the responsibility of the Behavioral Respite Services provider). Restraints shall not be used unless used in accordance with the department's policy on use of restraints.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Behavioral Respite Services shall be limited to a maximum of 60 days per waiver participant per waiver year.

Title: Day Services

Service Definition (Scope):

Day Services shall mean individualized services and supports that enable a person to acquire, retain, or improve skills in the area of self-care, sensory/motor development, socialization, daily living skills, communication, community living, employment, and social skills. Day Service therapeutic objectives and action steps are outlined in the Individual Support Plan (ISP)/plan of care during the person-centered planning process. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day between the hours of 7:30 a.m. and 6:00 p.m. as specified in the ISP/plan of care. Day Services may be provided to persons as a separate service where permitted under service specifications described in this waiver.

Community-based Day Services are designed to enable the person to become more independent, integrated, and productive in the community as well as assist the person to build relationships and natural supports. Community-based Day Services are designed such that the person spends the majority of his/her time, while participating in this service, actively engaged in activities in the community (i.e., not facility-based or in-home day services). Supervision, monitoring, training, education, demonstration, or support is provided to assist with the acquisition of skills in the following areas: leisure activities and community/public events, utilizing community resources (e.g. public transportation), acquiring and maintaining employment, educational activities, hobbies, unpaid work experiences (e.g. volunteer opportunities), and maintaining contact with family and friends.

Facility-based Day Services are provided in a licensed day habilitation facility. A facility-based provider may provide services in community locations such as community recreation centers or job sites on occasion.

Supported Employment Day Services are provided in accordance with the following requirements:

a. A job coach employed by the Day Services provider shall be on-site at the work location and shall supervise the person; or

b. The Day Services provider shall oversee the person's supported employment services including on-site supervisors, and shall have a minimum of three contacts per week with the person including at least one contact per week at the work site, and shall have a job coach employed by the Day Services provider who is available on-call if needed to go to the work site.

In-home Day Services are provided in the person's residence if there is a health, behavioral, or other medical reason or if the person has chosen retirement or is unable to participate in services outside the home: such as, community-based, facility-based, and supportive employment.

Additional Requirements

Transportation of the person to and from the person's place of residence to the location where Day Services will be provided shall be the responsibility of the Day Services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation that is needed during the time that the person is receiving

Day Services shall be the responsibility of the Day Services provider, and the cost of such transportation shall be considered to be included within the Day Services reimbursement rate.

Day Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program. Services provided by natural supports are not reimbursable and are excluded.

Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Day Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego.

The reimbursement for Supported Employment Day Services shall not include incentive payments, subsidies, or unrelated vocational training expenses: such as,

a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

b. Payments that are passed through to users of supported employment programs.

c. Payments for vocational training that is not directly related to a person's supported employment program.

Day Services shall be limited to a maximum of 5 days per week up to a maximum of 243 days per person per year. Family members who provide Day Services are required to implement services as specified in the Individual Support Plan (ISP). Reimbursement to family members shall be limited to forty (40) hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

Day Services shall be reimbursed in accordance with the requirements set forth herein.

The provider may receive the per diem reimbursement for Day Services if:

a. The person receives 6 hours of direct services comprised of any combination of Community-based, Facility-based, and or Supported Employment Day Services.

b. The person receives 6 hours of In-home Day Services. The reimbursement shall be the per diem rate for In-home Day Services.

c. The person receives at least 2 hours of Day Services and there is documentation that the person was unable to complete the full 6 hours of Day Services for reasons beyond the provider's control (e.g., sickness of the person).

Reimbursement for a combination of different Day Services (e.g., community-based, facility-based, and or supported employment) provided on the same day shall be made in accordance with the following:

a. If the person receives up to or in excess of 6 hours of a combination of Community-based and Facility-based Day Services, the reimbursement shall be the per diem reimbursement rate for the type of service provided for the greatest amount of time that day.

b. If the person receives up to or in excess of 6 hours of a combination of Day services that includes Supported Employment, the reimbursement shall be the per diem reimbursement rate for Supported Employment Day Services.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Day Services shall be limited to a maximum 5 days per week up to a maximum of 243 days per service recipient per year.

Title: Dental Services (Arlington Waiver only)

Service Definition (Scope):

Dental Services shall mean medically necessary:

a. Dental procedures (e.g., preventive dental services, fillings, root canals, extractions, periodontics, the provision of dentures, and other dental treatments to relieve pain and infection) which have dental procedure codes listed in the current "TennCare Maximum Reimbursement Rate Schedule for Dental Services" that is used specifically for HCBS waiver dental services; and

b. Intravenous sedation or other anesthesia services provided in the dentist's office by, and billed by, the dentist or by a nurse anesthetist or anesthesiologist who meets the waiver provider qualifications.

Orthodontic services are excluded from coverage.

Dental Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Dental Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Dental Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Dental residents in training may provide Dental Services if they work under the direct supervision of a licensed dentist who is physically present when such services are being provided and if the licensed dentist materially participates in the provision of the Dental Services.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Dental Services shall be limited to a maximum of $5,000 per waiver participant per waiver program year, and a maximum of $7,500 per waiver participant across three (3) consecutive waiver program years.

Title: Environmental Accessibility Modifications

Service Definition (Scope):

Environmental Accessibility Modifications shall only mean the following modifications to the waiver participant's place of residence:

a. Physical modifications to the interior of a waiver participant's place of residence to increase the waiver participant's mobility and accessibility within the residence;

b. Physical modifications to an existing exterior doorway of the waiver participant's place of residence to increase the waiver participant's mobility and accessibility for entrance into and exit from the residence;

c. A wheelchair ramp and modifications directly related to, and specifically required for, the construction or installation of the ramp; or as an alternative to a wheelchair ramp, a platform lift (to lift wheelchairs) and modifications directly related to, and specifically required for, the installation of a platform lift for one entrance into the residence;

d. Hand rails for exterior stairs or steps to increase the waiver participant's mobility and accessibility for entrance into and exit from the residence; or

e. Replacement of glass window panes with a shatterproof or break-resistant material when medically necessary based on a history of destructive behavior by the waiver participant.

The following are specifically excluded from coverage:

a. Any adaptation or modification of the home which is of general utility and is not of direct medical or remedial benefit to the waiver participant;

b. Any adaptation or modification which is considered to be general maintenance of the residence;

c. Any physical modification to the exterior of the waiver participant's place of residence or lot (e.g., driveways, sidewalks, fences, decks, patios, porches) that is not explicitly listed above as being covered;

d. Any physical modification to garage doors for entry of vehicles;

e. Any item that would be covered by the Medicaid State Plan/TennCare Program;

f. Construction of an additional room or modification of an existing room which increases the total square footage of the residence;

g. Construction of a new room within existing floor space (e.g., construction of an additional bathroom), including construction of new interior walls to subdivide existing rooms;

h. A second or additional wheelchair ramp when there is a functional wheelchair ramp for one entrance into the waiver participant's residence;

i. A wheelchair ramp when there is a functional platform lift (to lift wheelchairs) for one entrance into the waiver participant's residence; or a platform lift for entrance into the waiver participant's residence when there is a functional wheelchair ramp for one entrance into the residence;

j. Platform lifts for use inside the waiver participant's place of residence;

k. Stairway lifts, stair glides, or elevators or the installation, repair, or replacement of stairway lifts, stair glides, or elevators;

l. Repair or replacement of roofing or siding;

m. Installation, repair, replacement, or painting of ceiling, walls, or floors or installation, repair, or replacement of carpet or other flooring except:

   (1) When the need for such is directly related to and necessitated by another approved environmental accessibility modification (e.g., flooring or carpet repair when a doorway is widened); and

   (2) When the cost of such is included in the cost of the other approved environmental accessibility modification;

n. Rugs and floor mats;

o. Furniture, lamps, beds, mattresses, bedding, and overbed tables;

p. Water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;

q. Air conditioning or heating systems or units or the installation, repair, or replacement of air conditioning or heating systems or units;

r. Electrical generators; emergency electrical backup systems; batteries, or battery chargers;

s. Installation, repair, or replacement of electrical units or systems, except for the installation or replacement of electrical outlets which will be used for medical equipment;

t. Lights or lighting systems or the installation, repair, or replacement of lights or lighting systems; except for the installation or replacement of lights when the need for such is directly related to and necessary in order to complete another approved environmental accessibility modification;

u. Construction of additional exterior doorways or windows;

v. Any item that meets the waiver service definition of Specialized Medical Equipment, Supplies, and Assistive Technology;

w. Sprinklers and sprinkler systems; and

x. Costs for removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition (i.e., the condition before the modification was made).

Environmental Accessibility Modifications shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).

To facilitate community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge, Environmental Accessibility Modifications may be made to the waiver participant's place of residence during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. In such cases, the Environmental Accessibility Modification will not be considered complete until the date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver, and such date shall be the date of service for billing purposes.

Environmental Accessibility Modifications shall be available only for newly enrolled waiver participants, including (but not limited to) persons transitioning to the community from an institutional setting, and existing waiver participants who have recently experienced a significant loss of mobility function.

Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per waiver participant per three (3) consecutive waiver program years.

Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the department's policy on submission of bids. If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for an Environmental Accessibility Modification or the request will be denied.

If the waiver participant does not own the place of residence, there must be written approval from the landlord for the Environmental Accessibility Modification to be approved. Such written approval must acknowledge that the waiver participant will not be responsible for the costs of removing an Environmental Accessibility Modification in order to convert or otherwise restore the place of residence to its pre-existing condition.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Environmental Accessibility Modifications shall be limited to a maximum of $15,000 per waiver participant per three (3) consecutive waiver program years.

Title: Family Model Residential Support

Service Definition (Scope):

Family Model Residential Support (FMRS) shall mean a type of residential service where a waiver participant lives in the home of a trained caregiver who is a not family member. Family Model Residential Support includes individualized services and supports that enable the waiver participant to acquire, retain, or improve skills necessary to reside successfully in a family environment in the home of trained caregivers other than the family of origin.

The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, and meal preparation excluding cost of food), household chores essential to the health and safety of the waiver participant, budget management, attending appointments, and interpersonal and social skills building to enable the waiver participant to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

The caregivers shall be recruited, screened, trained prior to providing services, and supervised by the Family Model Residential Support provider agency. The Family Model Residential Support provider shall oversee the waiver participant's health care needs.

A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of funding source.

The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the waiver participant is not receiving Day Services or is not at school or work.

Therapeutic goals and objectives shall be required for waiver participants receiving Family Model Residential Support.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.

Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Family Model Residential Support shall not be provided in a home where a waiver participant lives with family members unless such family members are also waiver participants receiving Family Model Residential Support. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

Reimbursement for Family Model Residential Support shall not include payment for Family Model Residential Support provided by the spouse of a waiver participant. The Family Model Residential Support provider and provider staff shall not be the parent or custodial grandparent

of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Family Model Residential Support provided by such individuals.

Reimbursement shall not include payment made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Individual Transportation Services

Service Definition (Scope):

Individual Transportation Services shall mean non-emergency transport of a waiver participant to and from approved activities specified in the plan of care. Whenever possible, immediate family members, friends who are involved in providing supports and community agencies who can provide this service without charge should be utilized.

The following transportation services are excluded from coverage:

a. Transportation to and from medical services covered by the Medicaid State Plan/TennCare Program; and

b. Transportation of school aged children to and from school; and

c. Transportation to and from supported or competitive employment; and

d. Transportation that is the responsibility of the provider of a residential service (e.g., Intensive Behavioral Residential, Residential Habilitation, Medical Residential Services, Family Model Residential Support, or Supported Living) or that is the responsibility of the provider of Day Services or Behavioral Respite Services, since it would duplicate services that are the responsibility of the providers.

Individual Transportation Services shall not be provided by the spouse of a waiver participant and shall not be provided by the parent or custodial grandparent of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption, and reimbursement shall not be provided for Individual Transportation Services provided by such individuals.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Maximum of 31 days per month

Title: Intensive Behavioral Residential Services

Service Definition (Scope):

The Intensive Behavioral Residential Service is a clinical treatment model designed to meet the specific needs of each person supported by the program. The target population for this program is adults with intellectual disabilities who have exhibited high risk behavior, placing themselves and or others in danger of harm. This program is designed to be flexible enough to respond to the changing levels of need (LON) of the person supported and the level of risk (or lack thereof) presented by the person's current behavior. It is not an indefinite, long term, residential support service. A person with high risk behavior who is involved in this program will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.

Program leadership is provided by the agency Clinical Director, who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Administrative functions are performed by members of the agency management team.

1. Providers are licensed and operated as a mental retardation (i.e. Intellectual Disability) Residential Habilitation Facility.

2. Each residence is no larger than a four-person home.

3. Each home may have at least one safe area that provides a room or space to which a person may retreat in order to prevent or manage an escalating behavior.

4. The service:

    a. Includes an individual treatment plan which describes ongoing assessment and monitoring of the person supported and professional judgment regarding behavioral supervision, individual crisis plans, treatment objectives, and treatment planning. The individual treatment plan does not replace the federally required independent support plan/plan of care. Rather, it describes in detail the person's treatment needs, etc., as described above.

    b. Allows for persons supported to learn and complete activities of daily living necessary for successful social integration.

    c. Has staffing ratios that are designed to be flexible in order to meet the needs of people as events occur.

    d. Coordinates ancillary services that are flexible and responsive to the needs of the people supported. Ancillary services may be funded through the Managed Care Organization or the Medicaid Waiver; will vary according to the person's individual needs; and may include services such as counseling, psychotherapy, psychiatric consultation, medical, dental, and nursing and therapy services.

e. Provides behavior analyst services that are embedded within the service and are flexible and available as needed within a 24-hour period.

f. Ensures that DIDD Human Rights Committee and DIDD Behavior Support Committee approval is obtained prior to implementation of restrictive interventions, as necessary.

5. On-going safety and supervision may include:

a. An intensive person-centered planning approach including determining what is important to and for the person and supporting him/her to achieve those goals identified in this process.

b. A carefully structured environment and a highly structured schedule with pre-planned activities, which the person supported participates in choosing and scheduling.

c. Proactive behavioral intervention approaches and teaching alternative strategies.

d. Learning healthy methods of expression.

e. Remote monitoring in public areas of the home.

f. Alarms to notify staff of elopement.

g. Windows designed for safety.

h. Other measures as recommended and approved.

6. Daily activities may include but are not limited to the following:

a. Supported employment when appropriate.

b. The training of self-management.

c. Training in essential life skills to attain or maintain integration in the community.

d. Habilitation, based upon individual needs and program strategies, to teach tasks that will assist the person in getting ready for a typical workday (e.g., making lunch, using public transportation, etc.)

e. Community exploration and integration.

Target Population and Behaviors

This program is designed for adults with intellectual disabilities who exhibit high risk behaviors that are dangerous or whose behaviors are so serious that when they occur, they present a potential danger to the person, staff, or the community.

Examples of the behaviors that meet criteria are behaviors that have caused harm in the past (e.g., sexual predatory behavior) and have a probability of reoccurrence. These behaviors can be reasonably expected to occur in the absence of a highly structured therapeutic environment without support, supervision, and training in alternative behaviors. Specific examples include the following:

1. Directly causes serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others, or animals.

2. Sexually offensive behaviors with high frequency of occurrence or sexual behavior with any person who did not consent or is unable to consent to such behavior, or engaging in public displays of sexual behavior.

3. Criminal behavior.

4. Cause serious property destruction (e.g., fire setting).

Admission Review Process

The DIDD Central Office Admissions/Discharge Committee is responsible for reviewing and approving each person who is referred to the program. Referrals will be generated from persons supported who have been served at the highest levels of need (LON) in terms of intensity, supports, and services, yet have received minimal benefit from services at said level, and for whom Intensive Behavioral Residential Services offer a more appropriate and cost-effective service delivery model.

Referrals may also be generated for persons entering the system who have issues identified that are consistent with those noted for the target population and for whom Intensive Behavioral Residential Services offer a more appropriate and cost-effective service delivery model than services the person would otherwise require.

The DIDD Central Office Admissions/Discharge Committee will review referrals from state case managers, independent support coordinators, and DIDD providers. The DIDD Central Office Admissions/Discharge Committee is comprised of the Director of Behavioral and Psychological Services (Chair), selected clinicians, and DIDD central/regional office staff.

For each person referred to the program, the committee will review the following information: intake plan, independent support plan (ISP), risk assessment, clinical assessments, and health evaluations.

Continued Stay/Discharge Criteria

1. Continued placement in the program requires periodic (at least every six months or more frequently, as needed) evaluation by the agency Clinical Director, and approval by the DIDD Central Office Admissions/Discharge Committee of the continued likelihood of occurrence of presenting behaviors and progress/benefit in continuing the program. The agency Clinical Director shall submit recommendations regarding continued stay or discharge to the DIDD Central Office Admissions/Discharge Committee, who shall make the final determination.

2. An individual shall be considered for discharge if the individual has met the clinical objectives identified in the clinical plan or the individual/legal representative has refused to participate in treatment.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Medical Residential Services

Service Definition (Scope):

Medical Residential Services shall mean a type of residential service provided in a residence where all of the residents require direct skilled nursing services and habilitative services and supports that enable a waiver participant to acquire, retain, or improve skills necessary to reside in a community-based setting.

Medical Residential Services must be medically necessary. The waiver participant who receives Medical Residential Services must have a medical diagnosis and treatment needs that would justify the provision of direct skilled nursing services that must be provided directly by a registered nurse or a licensed practical nurse, and such services must be needed on a daily basis and at a level which cannot for practical purposes be provided through two or fewer daily skilled nursing visits and which cannot be more cost-effectively provided through a combination of waiver services and other available services. There must be an order by a physician, physician assistant, or nurse practitioner for one or more specifically identified skilled nursing services, excluding nursing assessment or oversight, that must be provided directly by a registered nurse or by a licensed practical nurse in accordance with the Tennessee Nurse Practice Act. Therapeutic goals and objectives shall be required for waiver participants receiving Medical Residential Services support.

The Medical Residential Services provider shall be responsible for providing an appropriate level of services and supports, including skilled nursing services, 24 hours per day 7 days a week when the waiver participant is not at school; however, a nurse is not required to be present in the home during those time periods when skilled nursing services are not medically necessary. One nurse can provide services to more than one waiver participant in the home during the same time period if it is medically appropriate to do so.

The Medical Residential Services provider shall be responsible for the cost of Day Services needed by the waiver participant and any skilled nursing services needed while receiving Day Services.

The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, and meal preparation excluding cost of food), household chores essential to the health and safety of the waiver participant, budget management, attending appointments, and interpersonal and social skills building to enable the waiver participant to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

A Medical Residential Services home shall have no more than 4 residents with the exception of those homes which were licensed as a Residential Habilitation Facility prior to July 1, 2000.
Medical Residential Services shall not be provided in schools or in institutional settings (e.g., inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities).

Medical Residential Services shall not be provided in a home where a waiver participant lives with family members unless such family members are also waiver participants receiving Medical Residential Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

Since the Medical Residential Services provider is responsible for providing direct support services, Day Services, and other services 24 hours per day 7 days per week when the waiver participant is not at school, a waiver participant who is receiving Medical Residential Services shall not be eligible to receive Personal Assistance, Day Services, or Respite. Medical Residential Services are not intended to replace services available through the Medicaid State Plan/TennCare Program.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Medical Residential Services and shall be included in the reimbursement rate for such.

Reimbursement for Medical Residential Services shall not be made for room and board or for the cost of maintenance of the dwelling if the home is rented, leased, or owned by the provider. If the home is rented, leased, or owned by the waiver participant, reimbursement shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the waiver participant and who provides services to the waiver participant in the waiver participant's place of residence. If a waiver participant owns or leases the place of residence, residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the waiver participant, other residents in the home, and (as applicable) live-in or other caregivers.

Reimbursement for Medical Residential Services shall not include payment made for services provided by the waiver participant's conservator. Reimbursement for Medical Residential Services shall not include payment for Medical Residential Services provided by the spouse of a waiver participant. The Medical Residential Services provider and provider staff shall not be the parent or custodial grandparent of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Medical Residential Services provided by such individuals.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Nursing Services

Service Definition (Scope):

Nursing Services shall mean skilled nursing services that fall within the scope of Tennessee's Nurse Practice Act and that are directly provided to the waiver participant in accordance with a plan of care. Nursing Services shall be ordered by the waiver participant's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services. Nursing Services shall be provided face to face with the waiver participant by a licensed registered nurse or licensed practical nurse under the supervision of a registered nurse. The waiver participant must require a specifically identified skilled nursing service, excluding nursing assessment and oversight, which state law requires to be performed by a nurse. Nursing assessment and/or nursing oversight shall not be a separate billable service under this definition. Nursing Services are not intended to replace services that can be appropriately provided by unlicensed direct care staff. Therapeutic goals and objectives shall be required for waiver participants receiving Nursing Services.

Nursing Services shall consist of 2 categories of services and reimbursement:

a. RN services – RN services shall mean skilled nursing services, as specified above, which are provided by a registered nurse. This includes those services which require the skills of a registered nurse and which are required by Tennessee's Nurse Practice Act to be performed by a registered nurse.

b. LPN services – LPN services shall mean skilled nursing services, as specified above, which are provided by a licensed practical nurse working under the supervision of a registered nurse and which are permitted by Tennessee's Nurse Practice Act to be performed by a licensed practical nurse working under the supervision of a registered nurse.

This service shall be provided in home and community settings, as specified in the Plan of Care, excluding schools, inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). A waiver participant who is receiving Medical Residential Services shall not be eligible to receive Nursing Services.

Nursing Services shall not be billed when provided during the same time period as other therapies unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently.

Nursing Services are not intended to replace either intermittent home health skilled nursing visits or private duty nursing services available through the Medicaid State Plan/TennCare program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the

waiver service. Nursing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Applicable limits, if any, on the amount, frequency, or duration of this service:
Nursing Services shall be limited to a maximum of 48 units (12 hours) per day per waiver participant.

Title: Nutrition Services

Service Definition (Scope):

Nutrition Services shall mean assessment of nutritional needs, nutritional counseling, and education of the waiver participant and of caregivers responsible for food purchase, food preparation, or assisting the waiver participant to eat. Nutrition Services must be provided in accordance with therapeutic goals and objectives specified in a plan of care developed by a dietitian or nutritionist. A dietitian or nutritionist who provides Nutrition Services must provide services within the scope of licensure and must be licensed as required by the State of Tennessee. Nutrition Services are intended to promote healthy eating practices and to enable the waiver participant and direct support professionals to follow special diets ordered by a physician, physician assistant, or nurse practitioner.

Nutrition Services must be provided face to face with the waiver participant except for waiver participant-specific training of caregivers responsible for food purchase, food preparation, or assisting the waiver participant to eat and except for that portion of the assessment involving development of the plan of care.

Nutrition Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Speech, Language, and Hearing Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently.

The unit of reimbursement for a Nutrition Services assessment with plan development shall be per day. The unit of reimbursement for other Nutrition Services shall be per day.

Reimbursement for a Nutrition Services assessment visit, which includes the Nutritional Services plan development resulting from such an assessment, shall be limited to one assessment visit per waiver participant per waiver program year. Nutrition Services other than the assessment (e.g., waiver participant-specific training of caregivers; monitoring dietary compliance and food preparation) shall be limited to a maximum of one visit per day.

Nutrition Services (including Nutrition Services assessments and other non-assessment services) shall be limited to a maximum of six (6) visits per waiver participant per waiver program year, of which no more than one (1) visit per waiver program year may be an assessment. A Nutrition Services assessment cannot be billed on the same day with other Nutrition Services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Nutrition Services unless provided by a licensed dietitian or nutritionist.

Nutrition Services are not intended to replace services available through the Medicaid State Plan/TennCare program.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Nutrition Services shall be limited to a maximum of six (6) visits per waiver participant per waiver program year, of which no more than one (1) visit per waiver program year may be a Nutrition Services assessment. Nutrition Services other than the assessment (e.g., waiver participant-specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day.

Title: Occupational Therapy

Service Definition (Scope):

Occupational Therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations involving performance of activities of daily living; and the initial training of provider staff on the appropriate implementation of the therapy plan of care.

Occupational Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist. Occupational Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the waiver participant except for that portion of the assessment involving development of the plan of care. Occupational Therapy therapeutic and corrective services shall not be ordered concurrently with Occupational Therapy assessments (i.e., assess and treat orders are not accepted).

Occupational Therapy shall be provided in accordance with a treatment plan developed by a licensed occupational therapist based on a comprehensive assessment of the waiver participant's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Occupational Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Occupational Therapy services shall require documentation of reassessment of the waiver participant's condition and continuing progress of the waiver participant toward meeting the goals and objectives.

Occupational Therapy shall not be billed when provided during the same time period as Physical Therapy; Speech, Hearing, and Language Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently. Occupational Therapy is not intended to replace services that would normally be provided by direct care staff.

Occupational Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Occupational Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for an Occupational Therapy assessment with plan development shall be per day. The unit of reimbursement for other Occupational Therapy services shall be per 15 minutes.

Reimbursement for an Occupational Therapy assessment with development of an Occupational Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per year per waiver participant per provider. Occupational Therapy services other than such assessments (e.g., waiver participant-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per waiver participant per day.

Occupational Therapy assessments shall not be billed on the same day with other Occupational Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Occupational Therapy unless provided by a licensed occupational therapist or by a licensed occupational therapist assistant working under the supervision of a licensed occupational therapist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

- 1 assessment with plan development per month.
- 3 assessments per year per provider.
- 1.5 hours per day for services other than assessments.

Title: Orientation and Mobility Services for Impaired Vision

Service Definition (Scope):

Orientation and Mobility Services for Impaired Vision shall mean services (1) to assess a waiver participant's orientation and mobility to determine functional limitations resulting from severe visual impairment and (2) to provide orientation and mobility training to enable a waiver participant with functional limitations resulting from severe visual impairment to move with greater independence and safety in the home and community environment.

Orientation and Mobility Services for Impaired Vision shall be based on a formal assessment of the waiver participant and may include concept development (i.e. body image); motor development (i.e., motor skills needed for balance, posture and gait); sensory development (i.e. functioning of the various sensory systems); residual vision stimulation and training; techniques for travel (indoors and outdoors) including human guide technique, trailing, cane techniques, following directions, search techniques, utilizing landmarks, route planning, techniques for crossing streets, and use of public transportation; and instructional use of Low Vision devices.

Orientation and Mobility Services for Impaired Vision shall be provided face to face with the waiver participant except for training of caregivers responsible for assisting in the mobility of the waiver participant and except for that portion of the assessment involving development of the plan of care. Therapeutic goals and objectives shall be required for waiver participants receiving Orientation and Mobility Services for Impaired Vision. Continuing approval of Orientation and Mobility Services for Impaired Vision shall require documentation of reassessment of the waiver participant's condition and continuing progress of the waiver participant toward meeting the goals and objectives.

Orientation and Mobility Services for Impaired Vision shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Behavior Services, or Speech, Language, and Hearing Services, unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently. Orientation and Mobility Services for Impaired Vision shall not replace services available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act.

The unit of reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with plan development shall be per day. The unit of reimbursement for other Orientation and Mobility Services for Impaired Vision shall be per 15 minutes. Reimbursement for an Orientation and Mobility Services for Impaired Vision assessment with development of the plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per year per waiver participant per provider. Orientation and Mobility Services for Impaired Vision assessments shall not be billed on the same day with other Orientation and Mobility Services for Impaired Vision services.

Orientation and Mobility Services for Impaired Vision services other than such assessments (e.g., waiver participant training; waiver participant-specific training of caregivers), which shall be reimbursed on a per diem basis, shall be limited to a maximum of 52 hours of services per waiver participant per year.

Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Orientation and Mobility Services for Impaired Vision unless provided by a Certified Orientation and Mobility Specialist (COMS) who is nationally certified through the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Applicable limits, if any, on the amount, frequency, or duration of this service:

- 1 assessment with plan development per month;
- 3 assessments per year per person per provider; and
- 52 hours of non-assessment services per year.

Title: Personal Assistance

Service Definition (Scope):

Personal Assistance shall mean the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the person (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the waiver participant); budget management, supervising and accompanying the person to medical appointments if needed, and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. Personal Assistance shall be provided in accordance with therapeutic goals and objectives as specified in the plan of care.

Personal Assistance is a service that is provided for the direct benefit of the person. It is not a service that provides assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver. Personal Assistance staff shall not provide any personal assistance services to family members of the person, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants).

When Personal Assistance is provided as a shared service for 2 or more family members who are waiver participants residing in the same home, the total number of units of shared Personal Assistance shall be apportioned based on an assessment of individual need and the apportioned amount included in the plan of care for each waiver participant, as applicable.

Personal Assistance is often delivered in the person place of residence; however, it may be provided outside the person home in community-based settings where the Personal Assistance provider accompanies the person to perform tasks and functions in accordance with the approved service definition and as specified in the plan of care. Personal Assistance does not include routine provision of Personal Assistance services in an area outside the person's waiver participant's local community of residence. On an infrequent and exceptional basis and in accordance with the approved plan of care, Personal Assistance services may be provided in an area outside the person's waiver participant's local community of residence.

Personal Assistance may be provided in the home or community; however, it shall not be provided in schools for school-age children, to replace personal assistance or similar services required to be covered by schools, to transport or otherwise take children to or from school, or to replace services available through the Medicaid State Plan/TennCare Program.

Personal Assistance services shall not be provided in the home of the Personal Assistant, except (1) when the waiver participant lives in the home with the Personal Assistant or (2) on an infrequent and exceptional basis when the person is attending a special event (e.g., a party) that is held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved ISP.

Personal Assistance may be provided during the day or night, as specified in the plan of care. A person who is receiving a residential service (e.g., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance.

Personal Assistant Services shall not be provided during the same time period that the person is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.

Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the person. The Personal Assistant shall not be the spouse of a person and shall not be the parent or custodial grandparent of a person under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Personal Assistance provided by such individuals. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Family members are required to implement services as specified in the individual support plan (ISP). Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person’s Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

The unit of reimbursement for Personal Assistance services shall be 15 minutes.

The Personal Assistance provider is not obligated to provide transportation for the person as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the person into the community.

Personal Assistance may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the person's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

b. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days per person supported per waiver program year.

c. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

d. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

e. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Personal Assistance services shall be limited to a maximum of 860 units (215 hours) per waiver participant per month. Out of state Personal Assistance services are subject to the same monthly limitation, and in addition, are limited to a maximum of 14 days per waiver participant per waiver program year.

Title: Personal Emergency Response Systems

Service Definition (Scope):

A Personal Emergency Response System shall mean a stationary or portable electronic device used in the waiver participant's place of residence which enables the waiver participant to secure help in an emergency. The system shall be connected to a response center staffed by trained professionals who respond upon activation of the electronic device. The system shall be limited to those who are alone for parts of the day and who have demonstrated mental and physical capability to utilize such a system effectively.

A Personal Emergency Response System shall consist of installation and testing of the Personal Emergency Response System as well as monthly monitoring performed by a response center.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Monitoring is limited to 1 unit/month (12 units per year) maximum.

Title: Physical Therapy

Service Definition (Scope):

Physical therapy shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure and which are provided to assess and treat functional limitations related to ambulation and mobility; and the initial training of provider staff on the appropriate implementation of the therapy plan of care.

Physical Therapy services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition. Services must be provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

Physical Therapy must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the waiver participant except for that portion of the assessment involving development of the plan of care.

Physical Therapy therapeutic and corrective services shall not be ordered concurrently with Physical Therapy assessments (i.e., assess and treat orders are not accepted).

Physical Therapy shall be provided in accordance with a treatment plan developed by a licensed physical therapist based on a comprehensive assessment of the waiver participant's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Physical Therapy to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Physical Therapy services shall require documentation of reassessment of the waiver participant's condition and continuing progress of the waiver participant toward meeting the goals and objectives.

Physical Therapy shall not be billed when provided during the same time period as Occupational Therapy; Speech, Language, and Hearing Services; Nutrition Services, Orientation and Mobility Services for Impaired Vision; or Behavior Services, unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently. Physical Therapy is not intended to replace services that would normally be provided by direct care staff.

Physical Therapy services are not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Physical Therapy shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for a Physical Therapy assessment with plan development shall be per day. The unit of reimbursement for other Physical Therapy services shall be per 15 minutes.

Reimbursement for a Physical Therapy assessment with development of a Physical Therapy plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per year per waiver participant per provider. Physical Therapy services other than such assessments (e.g., waiver participant-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per waiver participant per day. Physical Therapy assessments shall not be billed on the same day with other Physical Therapy services. Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Physical Therapy unless provided by a licensed physical therapist or by a licensed physical therapist assistant working under the supervision of a licensed physical therapist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

- 1 assessment with plan development per month;
- 3 assessments per year per provider; and
- 1.5 hours per day for services other than assessments.

Title: Residential Habilitation

Service Definition (Scope):

Residential Habilitation shall mean a type of residential service having individualized services and supports that enable a waiver participant to acquire, retain, or improve skills necessary to reside in a community-based setting including direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation), household chores) essential to the health and safety of the waiver participant, budget management, attending appointments, and interpersonal and social skills building to enable the waiver participant to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

The Residential Habilitation dwelling may be rented, leased, or owned by the Residential Habilitation provider and shall be licensed by the State of Tennessee. The Residential Habilitation provider shall provide personal funds management as specified in the plan of care. Therapeutic goals and objectives shall be required for waiver participants receiving Residential Habilitation. The Residential Habilitation provider shall oversee the waiver participant's health care needs.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports 24 hours per day during the hours the waiver participant is not receiving Day Services or is not at school or work. A waiver participant who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider).

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling. Reimbursement for Residential Habilitation shall not include payment for Residential Habilitation provided by the spouse of a waiver participant.

The Residential Habilitation provider and provider staff shall not be the parent or custodial grandparent of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Residential Habilitation provided by such individuals. Reimbursement shall not include payment made for services provided by the waiver participant's conservator.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Residential Habilitation shall not be provided in a home where a waiver participant lives with family members unless such family members are also waiver participants receiving Residential Habilitation. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Respite

Service Definition (Scope):

Respite shall mean services provided to a person when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness, or injury, or when unpaid caregivers need relief from routine caregiving responsibilities. Respite may be provided in the person's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/IID, in a home operated by a licensed residential provider, in a licensed respite care facility, or in the home of an approved respite provider. The Respite provider may also accompany the person on short outings for exercise, recreation, shopping or other purposes while providing respite care.

Reimbursement for Respite shall not include payment for Respite provided by the spouse of a person or family member or relative (whether by birth or marriage) who resides with the person in the home. The Respite provider and provider staff shall not be the parent or custodial grandparent of a person under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Respite provided by such individuals. Reimbursement for Respite shall not include payment for Respite provided by any other individual who has been appointed as the conservator for the person unless so permitted in the Order for Conservatorship. Family members who provide Respite must meet the same standards as providers who are unrelated to the person, including implementing services as specified in the individual support plan (ISP).

When less than 8 hours of respite services is needed in a day, the unit of reimbursement shall be per 15 minutes. When 8 hours or more of respite services are needed in a day, the unit of reimbursement shall be per day.

Level 1 per day reimbursement shall be for persons requiring at least 8 hours, but less than 16 hours of respite services in a day. Level 2 per day reimbursement shall be for persons requiring 24 hour respite services, but no awake overnight direct support staff. Level 3 per day reimbursement shall be for persons requiring 24 hour respite services with awake overnight direct support staff. Respite shall be limited to a maximum of 30 days per person per year.

Family members are required to implement services as specified in the individual support plan (ISP). Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person’s Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person-supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

Providers who receive the per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.

Respite Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Day Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof.

Respite Services shall not be used to replace or supplant personal assistance services.

Applicable limits, if any, on the amount, frequency, or duration of this service: Maximum of 30 days per person per year.

Title: Semi-Independent Living Services (Self-Determination waiver only)

Service Definition (Scope):

Semi-Independent Living Services (SILS) shall mean services that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community.

The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act.

This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. However, access to emergency supports as needed from the provider on a 24/7 basis is an essential component of this residential service and is what differentiates it from Personal Assistance services.

The Circle of Support must consider the person's level of independence and safety prior to establishing a semi-independent living arrangement. Safety considerations must be reviewed at least annually (and more often should a change of needs or circumstances warrant). Consideration regarding the use of a Personal Emergency Response System should be given when appropriate. The ISP must reflect the routine supports that will be provided by residential staff.

The person may choose to live with one or two other persons supported and share expenses or to live alone as long as sufficient financial resources are available to do so. No more than 3 persons receiving Semi-Independent Living Services will be permitted to share a residence. The person supported shall have the right to manage personal funds as specified in the Individual Support Plan.

Reimbursement for Semi-Independent Living Services shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person(s) supported and other residents in the home (if applicable).

A person who is receiving Semi-Independent Living Services shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Semi-Independent Living Services and shall be included in the reimbursement rate for such.

The Semi-Independent Living Services provider shall not own the person's place of residence or be a co-signer of a lease on the person's place of residence unless the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider.

The Semi-Independent Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different provider.

Semi-Independent Living Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID). Semi-Independent Living Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving Semi-Independent Living Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

On a case-by-case basis, the DIDD Commissioner or designee may authorize Semi-Independent Living services for a person supported who resides with his or her spouse and or minor children.

Semi-Independent Living Services shall not be provided out-of-state.

A minimum of two face-to-face direct service visits in the home per week are required for each person receiving Semi-Independent Living Services. However, providers delivering this service are required to implement provisions for availability of provider staff on a 24 hour basis in case emergency supports are needed.

Semi-Independent Living Services providers are required to be licensed as Mental Retardation (i.e., Intellectual Disabilities) Semi-Independent Living Providers.

Additional Facility Specifications for Semi-Independent Living Services:

Environments that can be used as semi-independent living sites shall include apartments or homes that are self-contained and include at least a kitchen, bathroom, living area, and one or more bedrooms.

As long as they have the financial resources to do so, people receiving semi-independent living services can choose to live alone. A person may also choose one or two house mates to share expenses with if they so desire. In no instance will there be more than three (3) service recipients living in one apartment/home. While a provider may facilitate introductions to potential house mates, only the person(s) living in the apartment, along with applicable input from legal guardians and/or conservators, may choose prospective house mate(s).

With support from family members and/or provider staff, people furnish and decorate their own apartment/home. As part of the supports provided, staff may transport people shopping, assist with hanging pictures, assist with financial management or other activities designed to assist the person in setting up their own apartment/home, etc.

Support staff will be available to assist people with food stamp applications, grocery shopping etc. and will be expected to ensure people have adequate food supplies. People will have unrestricted access to their kitchen/food supplies. They will decide how they want to spend their time and what activities they wish to participate in. Staff will support them to participate in activities of their choosing as they desire.

The apartment/home is under the control of the person(s) who live there and there are no restrictions on visitors of their choosing. Should issues arise, the person and their circle of support would work to resolve them on an individualized basis.

Service recipients' privacy will be ensured with lockable entrance doors. With guidance from their circle of support, service recipients will choose whether to share keys with support staff. Should the provider own the residence, as the landlord they would retain a key to the premises for emergency purposes as any landlord would.

Prior to an initial move into a semi-independent living apartment/home, if the person has mobility issues, a therapeutic site assessment may be completed to determine home modifications that might be needed. Minor modifications may be completed in accordance with waiver protocols within the individual's Waiver budget. The owner of the property may choose to make adaptations as appropriate.

There must be a legally enforceable lease agreement between the person supported and the landlord. Such an agreement must be in compliance with landlord/tenant laws of the state applicable for any tenant under a lease agreement.

Lease Requirements Applicable to Semi-Independent Living Services:

The following requirements are applicable regarding lease arrangements for persons receiving semi-independent living services:

1) The preferred lease option is for the home lease to be signed by the person supported or legal representative.

2) A provider may co-sign a lease with a person supported in order to increase the selection of housing options available to the person, but may not be the sole lease holder. A provider would not be expected to co-sign the lease with the person supported if the provider owns the home.

3) If a provider does co-sign a lease with a person supported, the provider must also sign a written agreement with the person supported stating that the person will not be required to move or pay an increased lease payment due to a change of semi-independent living providers.

4) If a provider owns a semi-independent living home leased to a person supported, the provider shall not require as a condition of the lease agreement that the person move if a different semi-independent living provider is chosen. The lease agreement shall specify

that the service recipient will not be forced to move should the person choose to be supported by a different provider agency.

5) A provider may not be affiliated with the owner of a semi-independent living home leased to a person supported if the entity owning the home requires that the person move as a condition of the lease if a different semi-independent living provider is chosen.

6) A change in provider shall not require the person to change residences. Should the person supported wish to change provider agencies, such transition shall proceed in accordance with person-centered transition planning processes set forth in the Community Transition Policy. This process requires that the wishes and desires of the person supported be considered by the circle of support (COS) and incorporated into the planning process. The person and legal representative, if applicable, in conjunction with the COS shall determine if the proposed transition is in the person's best interests. Logistics of the transition, including disposition of co-signed leases, will be worked out during the transition process.

7) The owner of a semi-independent living home may not be an employee or board member employed or appointed by the semi-independent living provider.

8) The lease must provide for a sixty (60) day notice to the person supported prior to termination of the lease agreement or increase in the rent or lease amount.

9) The rental payment or lease amounts shall not exceed fair market value for similar property in the same general location.

10) The term of the rental or lease agreement shall not exceed one (1) year unless specified in the ISP and in the best interests of the person supported for purposes of obtaining a home with accessibility modifications.

11) In the event that a multi-year agreement is desired and meets the aforementioned standards, an annual increase of no more than 3% of the annual lease value may be contained within the lease agreement.

12) No more than one month's rent may be charged as a security deposit.

13) All notices related to termination of or changes in the lease agreement must be provided to the person supported, and/or legal representative or other person designated by the person.

Availability of Mortgage/Lease Documentation:

Individual leases and mortgage documentation must be accessible to auditors and surveyors representing CMS, TennCare, DIDD and other state and federal agencies responsible for regulation and oversight of DIDD programs. Lease/mortgage payment information must also be

available for review if the provider is involved with assisting the person supported in managing financial resources.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Specialized Medical Equipment and Supplies and Assistive Technology

Service Definition (Scope):

Specialized Medical Equipment and Supplies and Assistive Technology shall only mean the following:

a. An assistive device or adaptive aid or control designed for individuals with special functional needs which:

   (1) Increases the ability to perform activities of daily living (e.g., adaptive eating utensils and dishware; an adaptive toothbrush); or

   (2) Increases the ability to communicate with others (e.g., a hearing aid; an augmentative alternative communication device or system; an adaptive phone for individual with visual or hearing impairments); or

   (3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); and

b. A stander or standing table; and

c. A gait trainer; and

d. A sidelyer or similar positioning device; positioning wedges or rolls or similar positioning items; and

e. Supplies necessary for the proper functioning of specialized medical equipment or assistive technology covered within the scope of this waiver definition; and

f. Repair of specialized medical equipment or assistive technology devices covered within the scope of this waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it.

Specialized Medical Equipment, Supplies, and Assistive technology shall be medically necessary and shall be recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist).

The following items are excluded from coverage:

a. Items not of direct medical or remedial benefit to the waiver participant;

b. Items covered by the Medicaid State Plan/TennCare Program;

c. Hearing aids and augmentative alternative communication systems for children under age 21 years;

d. Eyeglasses, frames, and lenses;

e. Elevators, stairway lifts, stair glides, platform lifts, stair-climbing devices, electric powered recliners, elevating seats, and lift chairs;

f. Sensory processing/sensory integration equipment or other items used in sensory integration therapy (e.g., ankle weights, weighted vests or blankets, sensory/therapy balls, swings, vibrators, floor mats, balance boards, brushes, trampolines);

g. Carpets, rugs, flooring, floor pads and mats; curtains, drapes, and window treatments; furniture, lamps, and lighting;

h. Beds, mattresses, bedding, and overbed tables;

i. Air conditioning systems or units, heating systems or units; water purifiers, air purifiers, vaporizers, dehumidifiers, and humidifiers;

j. Electrical generators, electrical service, or emergency electrical backup systems;

k. Adaptive devices for use with items specifically excluded by this waiver definition;

l. Recreational or exercise equipment and adaptive devices for such; adaptive tricycles;

m. Toys, toy equipment, and adaptive devices for toys (e.g., flash switches);

n. Radios, televisions, or related electronic audiovisual equipment (e.g., DVD players); telephone, television, or internet service; and equipment or items for education, training, or entertainment purposes;

o. Personal computers; printers, monitors, scanners, and other computer-related hardware and software (excluding equipment designed specifically and primarily to be used as an augmentative alternative communication systems for adults);

p. Orthotics;

q. Stethoscopes or blood pressure cuffs;

r. Clothing;

s. Diapers and other incontinence supplies;

t. Food, food supplements, food substitutes (including formulas), and thickening agents;

u. Prescription and over-the-counter medications; vitamins, minerals, and nutritional supplements;

v. Swimming pools, hot tubs, whirlpools and whirlpool equipment, and health club memberships;

w. Lifting and tracking systems for transfer of waiver participants;

x. Supplies other than those supplies specifically required for the proper functioning of specialized medical equipment or assistive technology devices that are covered within the scope of this definition;

y. Duplicate items of specialized medical equipment or assistive technology, excluding adaptive eating utensils and dishware, to provide the waiver participant with a backup or spare;

z. Repair of equipment covered by warranty;

aa. Physical modification of the interior or exterior of a place of residence; and

bb. Physical modification of a motor vehicle or motor vehicle parts and services, including adaptive devices to facilitate driving.

Specialized Medical Equipment, Supplies and Assistive Technology is not intended to replace services available through the Medicaid State Plan/TennCare Program or services available under the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act. To the extent that such services are covered, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service.

Reimbursement shall be subject to approval of an itemized competitive bid as required in accordance with the department's policy on submission of bids.

If the requirement for an itemized competitive bid is applicable, documentation of an approved bid must be submitted with the request for the Specialized Medical Equipment, Supplies, and Assistive Technology or the request will be denied.

The purchase price for waiver-reimbursed Specialized Medical Equipment, Supplies and Assistive Technology shall be considered to include the cost of the item as well as basic training on operation and maintenance of the item.

Applicable limits, if any, on the amount, frequency, or duration of this service:
Specialized Medical Equipment, Supplies and Assistive Technology shall be limited to a maximum of $10,000 per waiver participant per 2 waiver program years.

Title: Speech, Language, and Hearing Services

Service Definition (Scope):

Speech, Language, and Hearing Services shall mean medically necessary diagnostic, therapeutic, and corrective services which are within the scope of state licensure which are provided to assess and treat functional limitations involving speech, language, or chewing/swallowing and the initial training of provider staff on the appropriate implementation of the therapy plan of care. Speech, Language, and Hearing Services provided to improve or maintain current functional abilities as well as prevent or minimize deterioration of chronic conditions leading to a further loss of function are also included within this definition.

Services must be provided by a licensed speech language pathologist or by a licensed audiologist. Speech, Language, and Hearing Services must be ordered by a physician, physician assistant, or nurse practitioner and must be provided face to face with the waiver participant except for that portion of the assessment involving development of the plan of care. Speech, Language, and Hearing therapeutic and corrective services shall not be ordered concurrently with Speech, Language, and Hearing assessments (i.e., assess and treat orders are not accepted).

Speech, Language, and Hearing Services shall be provided in accordance with a treatment plan developed by a licensed speech language pathologist or a licensed audiologist based on a comprehensive assessment of the waiver participant's needs and shall include specific functional and measurable therapeutic goals and objectives. The goals and objectives shall be related to provision of Speech, Language, and Hearing Services to prevent or minimize deterioration involving a chronic condition which would result in further loss of function. Continuing approval of Speech, Language, and Hearing Services shall require documentation of reassessment of the waiver participant's condition and continuing progress of the waiver participant toward meeting the goals and objectives.

Speech, Language, and Hearing Services shall not be billed when provided during the same time period as Physical Therapy, Occupational Therapy, Nutrition Services, Orientation and Mobility Services for Impaired Vision, or Behavior Services, unless there is documentation in the waiver participant's record of medical justification for the two services to be provided concurrently.

Speech, Language, and Hearing Services are not intended to replace services that would normally be provided by direct care staff or to replace services available through the Medicaid State Plan/TennCare Program. To the extent that such services are covered in the Medicaid State Plan/TennCare Program, all applicable Medicaid State Plan/TennCare Program services shall be exhausted prior to using the waiver service. Speech, Language, and Hearing Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

The unit of reimbursement for a Speech, Language, and Hearing Services assessment with plan development shall be per day. The unit of reimbursement for other Speech, Language, and Hearing Services shall be per 15 minutes.

Reimbursement for a Speech, Language, and Hearing Services assessment with development of a Speech, Language, and Hearing Services plan based on such an assessment shall be limited to a maximum of one assessment with plan development per month with a maximum of 3 assessments per year per waiver participant per provider. Speech, Language, and Hearing Services other than such assessments (e.g., waiver participant-specific training of caregivers; provision of therapeutic services; monitoring progress) shall be limited to a maximum of 1.5 hours per waiver participant per day. Speech, Language, and Hearing Services assessments shall not be billed on the same day with other Speech, Language, and Hearing Services.

Reimbursement shall not be made for telephone consultations. A provider shall not receive reimbursement for Speech, Language, and Hearing Services unless provided by a licensed speech language pathologist or by a licensed audiologist.

Applicable limits, if any, on the amount, frequency, or duration of this service:

- 1 assessment with plan development per month
- 3 assessments per year per provider
- 1.5 hours per day for services other than assessment

Title: Support Coordination

Service Definition (Scope):

Support Coordination shall mean case management services that assist the waiver participant in identifying, selecting, obtaining, coordinating, and using both paid services and natural supports to enhance the waiver participant's independence, integration in the community, and productivity as specified in the waiver participant's plan of care.

Support Coordination shall be person-centered and shall include, but is not limited to, ongoing assessment of the waiver participant's strengths and needs; development, evaluation, and revision of the plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including waiver participant rights and responsibilities; and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g., reporting, referring, or appealing to appropriate entities). It shall also include at least one face-to-face contact with the waiver participant per calendar month. If the waiver participant receives a residential service, the Support Coordinator shall have one face-to-face contact with the waiver participant in the waiver participant's place of residence each quarter.

Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Support coordinators shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Supported Living

Service Definition (Scope):

Supported Living shall mean a type of residential service having individualized services and supports that enable a waiver participant to acquire, retain, or improve skills necessary to reside in a home that is under the control and responsibility of the residents. The service includes direct assistance as needed with activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the waiver participant, budget management, attending appointments, and interpersonal and social skills building to enable the waiver participant to live in a home in the community. It also may include medication administration as permitted under Tennessee's Nurse Practice Act.

The Supported Living provider shall not own the waiver participant's place of residence or be a co-signer of a lease on the waiver participant's place of residence unless the Supported Living provider signs a written agreement with the waiver participant that states that the waiver participant will not be required to move if the primary reason is because the waiver participant desires to change to a different Supported Living provider.

A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a waiver participant if such entity requires, as a condition of renting or leasing, the waiver participant to move if the Supported Living provider changes. The waiver participant (or the waiver participant's legal representative acting on behalf of the waiver participant) shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports. The waiver participant shall have the right to manage personal funds as specified in the Individual Support Plan.

A Supported Living home shall have no more than 3 residents including the waiver participant. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence pass a home inspection approved by the State Medicaid Agency.

Therapeutic goals and objectives shall be required for waiver participants receiving Supported Living. The Supported Living provider shall oversee the waiver participant's health care needs.

The Supported Living provider shall be responsible for providing an appropriate level of services and supports 24 hours per day (unless otherwise indicated in the plan of care/ISP) during the hours the waiver participant is not receiving Day Services or is not at school or work. Thus, a waiver participant who is receiving Supported Living shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Supported Living provider).

Supported Living shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Supported Living shall not be provided in a home where a waiver participant lives with family members unless such family members are also waiver participants receiving Supported Living.
Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption. With the exception of the provider's live-in caregiver staff (if applicable), only Supported Living waiver participants shall be allowed to reside in the Supported Living home.

Except for waiver participants who were already receiving Supported Living on December 31, 2009, Supported Living shall not be covered for waiver participants under age 18 years (since the Supported Living home must be "under the control and responsibility of the residents", and only adults age 18 and older can legally assume such responsibility).

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.

Reimbursement for Supported Living shall not include payment for Supported Living provided by the spouse of a waiver participant. The Supported Living provider and provider staff shall not be the parent or custodial grandparent of a waiver participant under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Supported Living provided by such individuals.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the waiver participant and who provides services to the waiver participant in the waiver participant's home. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the waiver participant, other residents in the home, and (as applicable) live-in or other caregivers.

Applicable limits, if any, on the amount, frequency, or duration of this service: None

Title: Transitional Case Management

Service Definition (Scope):

Transitional Case Management shall mean case management services provided for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or other institutional setting who has been determined to qualify for HCBS waiver services upon discharge during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. Transitional Case Management shall assist the waiver participant in identifying, selecting, and obtaining both paid services and natural supports to enhance the waiver participant's independence, integration in the community, and productivity as specified in the waiver participant's transitional plan of care. Transitional Case Management shall be person-centered and shall include, but not be limited to, ongoing assessment of the waiver participant's strengths and needs; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including waiver participant rights and responsibilities; and monitoring implementation of the transitional plan of care. Transitional case management shall include at least one face-to-face contact with the waiver participant per calendar month. The date the person leaves the ICF/IID or other institutional setting and is enrolled in the waiver shall be the date of service for billing purposes.

Applicable limits, if any, on the amount, frequency, or duration of this service: The last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver.

Title: Vision Services (Arlington Waiver only)

Service Definition (Scope):

Vision Services shall mean routine eye examinations and determination of refraction; standard or special frames for eyeglasses; standard, bifocal, multifocal, or special lenses for eyeglasses; contact lenses; and dispensing fees for ophthalmologists, optometrists, and opticians.

Vision Services are not intended to replace services available through the Medicaid State Plan/TennCare program. All Vision Services for children enrolled in the waiver are provided through the TennCare EPSDT program. Vision Services shall not be covered for children under age 21 years (since it would duplicate TennCare/EPSDT benefits).

Applicable limits, if any, on the amount, frequency, or duration of this service: None